Chapter 4
Ensuring a Quality Health Care Workforce

A quality health care workforce serves as the backbone of the health care system. Efforts to improve the quality of the workforce involve health care professionals, clients, third-party payers, government regulators, and investors in private health facilities and organizations. With the onset of managed care, health professions regulation has become increasingly important and controversial. The proliferation of managed care has been so rapid that the efforts of consumers, state and federal government policymakers, and health professionals to adapt have been reactive, piecemeal, and largely determined by the forces of the health care market.[1]

Consumers are demanding assurances about the quality of their care and the competence of the professionals delivering it. State governments, charged to protect the well-being of their citizens, are making policy decisions related to funding health professions education, regulating health professions, and determining professional scopes of practice. Health professionals worry about their autonomy and scopes of practice. Managed care institutions, meanwhile, are concerned that health professionals' education and training are not preparing them with the skills required in the changing health care environment.

In their article, "Health Care Market Reforms and their Effect on Health Professions Regulation," O'Neil, Finocchio, and Dower state:

> What was until recently a relatively stable set of relationships between institutions, professionals, regulators, purchasers, and payors had degraded into a free for all of leveraged buyouts, mergers, closures and redefinitions of professional practice all contributing to a general sense of weightlessness and unease throughout the health care sector.[2]

One reason for this unease is that the interests and values of all the parties involved are very complex and not easily reconciled. Governments are charged with protecting the health and well-being of the public. Consumers are concerned about choice and quality of service. Health professionals' want to protect or enhance their autonomy. The health care industry is concerned with cost containment.

This chapter focuses primarily on the crucial issues in health professions regulation: continued competency, the roles and responsibilities of health professions boards, and scope of practice. These are the three main areas that contribute to the assurance of a quality health care workforce for Texas. The chapter includes a look at the recommendations from the Pew Commission Task Force on Health Care Workforce Regulation, initiatives in other states, and the current status of regulatory issues in Texas.

Health Professions Regulation

In 1989, the Pew Health Professions Commission established the Center for the Health Professions at the University of California at San Francisco and created a Task Force on Health Care Workforce Regulation. The task force was charged with exploring how regulation protects the public's health and with proposing new approaches to state oversight of health care professionals. The task force report, titled "Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century," was released in December 1995.

The Pew Task Force Report proposes the following principles for the health care regulatory system. They are:

- Promoting effective health outcomes and protecting the public from harm;
- Holding regulatory bodies accountable to the public;
- Respecting consumers' right to choose their health care providers from a range of safe options;

- Encouraging a flexible, rational and cost-effective health care system that allows effective working relationships among health care providers; and
- Facilitating professional and geographic mobility of competent providers.[3]

In their research on health professions regulations, the Pew Task Force came to the following conclusions. Regulation exists in 50 separate state systems which limits effective professional practice and mobility, presents barriers to integrated delivery systems and inhibits the use of emerging technologies such as telemedicine. Scope of practice laws, which are unique to each state, erect barriers to high-quality, affordable care. There is the perception that regulatory bodies are unaccountable to the public they serve and that these regulatory bodies do not effectively protect the public by ensuring continuing competence of health professionals through effective complaint and discipline processes or disclosure of practitioner information for consumers to make informed choices.

The report makes ten recommendations for state governments and health professions boards. With each recommendation, policy options are offered for states to consider. The Pew Commission Report has been the subject of much discussion and debate. In December 1997, the Pew Commission published "Considering the Future of Health Care Workforce Regulation: Responses from the Field," a follow-up document to the 1995 report.[4] This report is an analysis of 76 formal written responses made by the public to the 1995 report. The analysis is based on the level of concern for the recommendation and the level of support expressed for specific recommendations. The recommendations generating the highest level of concern among the respondents were those related to 1) assuring continuing competence, 2) titles and scopes of practice, and 3) redesigning board structure and functions.[5] What follows is a more detailed discussion of those recommendations.

Continuing Competency

The Pew Task Force on Health Care Workforce Regulation recommends the following action be taken by states to ensure the continuing competency of health care professionals practicing in their state:

> States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.[6]

While there were high levels of concern related to the recommendation on "assuring the continuing competency of health care practitioners," it also received one of the highest scores for support in the "Responses from the Field" report.[7]

PEW HEALTH PROFESSIONS COMMISSION
TASKFORCE ON HEALTH CARE WORKFORCE REGULATION

Summary of the 10 Recommendations

Recommendation 1: States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.

Recommendation 2: States should standardize entry-to-practice requirements and limit them to competence assessments for health professions to facilitate the physical and professional mobility of the health professions.

Recommendation 3: States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professions to provide services to the full extent of their current knowledge, training, experience and skills.

Recommendation 4: States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.

Recommendation 5: Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.

Recommendation 6: Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.

Recommendation 7: States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.

Recommendation 8: States should maintain a fair, cost-effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.

Recommendation 9: States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies to best protect and promote the public's health.

Recommendation 10: States should understand that links, overlaps and conflicts between their health care workforce regulatory systems and other systems that affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.

The issue of continuing competency is not a new one. In 1967, a commission on health manpower sponsored by the U.S. Department of Health, Education and Welfare suggested that physicians

undergo periodic reexamination. There was significant opposition to the idea of testing or reexamination and a similar report in 1971 suggested that states include specific requirements to ensure continued competency. Over the years, those "specific requirements" have been translated, almost universally, into a specified number of hours of continuing professional education to maintain licenses or certifications.[8]

In 1981, a report on health occupational credentialing from the U.S. Department of Health and Human Services, Bureau of Health Professions stated that:

> Continuing education has been adopted by state licensing boards, professional associations and certifying agencies on a widespread basis [yet there is a] lack of evidence of [a] positive relationship between continuing education courses and continued competency as measured by enhanced level of practitioners' skill and knowledge.[9]

More recent research indicates that there is little correlation between participation in continuing education programs and job performance.[10] States have struggled to deal with the disconnect between continuing education and the assurance of continuing competency. Virginia, for example, has addressed concerns about continuing competence by applying more stringent enforcement of continuing education guidelines. Colorado eliminated all mandatory continuing education hours for physicians in 1984 and for nurses in 1994.[11]

Despite their questionable effectiveness, more state boards every year adopt mandatory continuing education requirements for relicensing or certification. The Council on Licensure, Enforcement and Regulation states that one reason for the proliferation of continuing professional education is "that the quest for alternatives to mandatory continuing education has not resulted in any significant breakthroughs."[12]

> The 1997 Scott and White Assembly report, titled "America's Health: Seeking Solutions for the 21st Century," states that "the process of continuing medical education remains largely inadequate and is not meeting the needs of patients or providers."[13] The report posits the following reforms for continuing professional education:
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> - Courses should be more experienced-based instead of didactic.
> - Quality needs to be improved.

- There should be mandatory, periodic, specialty-specific recertification that includes competency in technical skills.
- Special skills such as management, computer literacy, business, population strategies, evidence-based medicine, and outcomes management should be part of the continuing medical education curriculum.

Marla Rothouse with the Health Policy Tracking Service states that:

> Given the advances in technology and the expanding scopes of practice for many professions in today's ever-changing health care environment, most experts agree that the current licensure renewals standards are inadequate and that competency should be reevaluated throughout a provider's career. Despite this acknowledgment, no state is actively pursuing the area of continued competency.[14]

In some measure, the health professions themselves are working to address concerns about continued professional competency. Below are some examples:

- The Federation of State Medical Boards, the National Commission on Certification of Physician Assistants and the National Council of State Boards of Nursing are developing new continued competency models.[15]
- The Federation of State Medical Boards has moved for "time-limited certifications" so that physicians may be reexamined.[16] Currently some medical specialty boards require rigorous demonstrations of competence for both initial and continued specialty certification. The American Board of Family Practice requires demonstrated competence through testing and records review every seven years.[17]
- The Federation of State Medical Boards and the National Board of Medical Examiners are working to establish a post-licensure assessment center. The center will use computer-based case simulations, a technique called "standardized patients," and other mechanisms to evaluate competency.[18]
- The National Council of State Boards of Nursing is developing a clinical simulation testing model for entry and continuing competency and has identified three possible competency standards: 1) entry level; 2) generalist core; and 3) focused area.[19]
- The Interprofessional Workgroup on Health Professions, a coalition of 17 health

organizations, is conducting research into competency assurance models and has recommended three types of competency assessments: formal education, supervised clinical experiences, and examinations.[20]

In the 1970s the question of institutional licensure was raised and advanced by a Professor Nathan Hershey at the University of Pittsburgh. Professor Hershey proposed that institutions should take responsibility for credentialing their staff, thereby assuring the quality of care within their own institution. At that time, the issue garnered little support. However, in today's managed care environment, it is being discussed once more. While it is important that organizations ensure that their staffs are competent, those opposed to institutional licensure argue that regulatory boards are accountable to the legislature and the public, while provider organizations are accountable to their stockholders.[21]

Texas is one of the first states to respond to the challenge of assuring continuing professional competence. Following the release of the Pew Health Professions Commission Report on reforming health care workforce regulation, the Texas Nurses Association and other professional nursing organizations began reviewing the recommendations on competency requirements for health care professionals. Information regarding mechanisms available for assuring competency and their relative effectiveness and cost benefit were limited. Nursing, with over 150,000 Texas licensees, felt that certain elements needed to be determined before actually enacting legislation. Therefore in 1997 during the 75th Legislative session, a bill was introduced and passed (Senate Bill 617) directing the Texas Board of Nurse Examiners to develop pilot programs to evaluate the effectiveness and cost benefit of a variety of mechanisms for assuring continued competency by registered nurses. Two areas proposed for evaluation are peer review and targeted continuing education. In November 1997, the Board of Nurse Examiners convened its Competency Advisory Committee. Over the next three years, committee members will consult in the development, approval, administration, and funding of continued competency pilot programs resulting in recommendations to the legislature in 2001.[22]

Redesigning Health Care Regulatory Boards

State boards have a wide range of responsibilities and powers that affect practitioners and the public. Depending upon the guidelines established through state legislation, state regulatory boards may have

responsibility for some or all of the following:

- specifying prelicensure requirements such as education and experience;
- preparing, grading, and administering examinations to determine competency;
- promulgating rules and regulations governing the practice and conduct of licensees; and
- receiving complaints, conducting investigations, holding hearings and taking disciplinary actions.[23]

Most state regulatory boards are made up of unpaid volunteer or appointed members who are usually members of the profession they are charged to regulate.

> This combination of self-regulation with the authority of the state has generated concerns. The considerable autonomy and independence with which professional boards regulate their respective professions has led to criticisms that professional self-interest and conflict of interests are inherent in self-regulation.[24]

In the past, the issues of health professions regulation were discussed and determined by the professions and their board representatives. In today's highly political health care environment, these discussions are taking place in an expanded number of public forums by a more diverse group consisting of consumers, managed care providers, legislators, and community leaders.[25]

The Pew Commission Report on workforce regulation proposes some of the following policy options for state consideration in the redesign of health professionals boards. They suggest the establishment of an interdisciplinary oversight board, the consolidation of the structure and function of boards around related health professional or health services, the inclusion of more public members and members from the health care delivery system on boards, and selection criteria for board members and training that allows them to serve with credibility and accountability.[26]

Efforts at health care reform, including health care regulation reform, have devolved to the states. Some, like Maine, began their reform efforts in 1993 with the establishment of the Medical Care Development's Health Professions Regulation project. This project was to conduct a comprehensive review of health professions regulation issues and make recommendations to the state legislature.

This task force has been ongoing and has submitted reports to the legislature in 1995 and 1997. Maine has developed some model legislation in the areas of the collection of health services data and scopes of practice. [27]

Given the complexity of reforming licensure systems, few states have instituted comprehensive reform measures. However, in 1996 and 1997 several states began examination of their regulatory systems and took legislative action. Some measures taken include:

- Arizona established a Health Professions Regulation Study Committee.
- Arkansas adopted a resolution requiring a feasibility study before introduction of any legislation related to the licensure of any profession.
- Connecticut proposed legislation to establish a task force to study the regulation of health professions.
- Iowa established a 37-member task force to evaluate the state's regulatory structures.
- Nebraska legislation requires the director of regulation and licensure to conduct a comprehensive study of the credentialing system and develop a model credentialing process for the state.
- Oregon considered legislation creating a health care licensing oversight committee to standardize procedures, budgets, and conflicts between various professions.
- Virginia the 17-member Board of Health Professions was charged with developing criteria to determine whether professions should be regulated.[28]

The 73rd Texas Legislature established the Health Professions Council (HPC) in Senate Bill 674. That council is composed of the 12 agencies that license 29 health professions. The rationale for the creation of the council was that through the collaboration of these independent boards, the following outcomes could be achieved:

- Coordination of overall policy;
- Economies of scale;
- Standardization of functions;
- Improved public access to services; and
- The potential for better enforcement.

The HPC was specifically charged with establishing a toll-free telephone complaint system for persons making a complaint relating to any health profession regulated by the state. That system has been in operation since November of 1995 and provides 24-hour referral services. During 1997, the complaint line received 3,200 calls.

The HPC also was directed to establish training and guidelines for members of stateboards and commissions. The training developed by the council in 1995 was updated in 1997 in cooperation with the Attorney General's Office to reflect revisions in the government code. This training manual has been well received by board members and it has served as a model for other Texas agencies as well as boards in other states.

The Health Professions Council

- Texas Board of Chiropractic Examiners
- Texas State Board of Dental Examiners
- Texas State Board of Medical Examiners
- Board of Nurse Examiners for the State of Texas
- Texas Optometry Board
- Texas State Board of Pharmacy
- Executive Council of Physical Therapy and Occupational Therapy Examiners
- Texas State Board of Podiatric Medical Examiners
- Texas State Board of Examiners of Psychologists
- Texas State Board of Veterinary Medical Examiners
- Texas Board of Vocational Nurse Examiners
- Texas Department of Health, Professional Licensing and Certification Division

The HPC conducted a feasibility study for co-locating the licensing boards, and all except the professions licensed by the Texas Department of Health are now located in the Hobby Building in downtown Austin. This co-location has allowed those agencies to achieve greater administrative efficiencies through shared purchasing and accounting functions, reduction in the costs of licensing the process, and consolidation of library resources.

Finally, the HPC is to submit an annual report to the governor, lieutenant governor, and the speaker of the House of Representatives addressing enforcement actions taken by boards, recommendations for statutory changes to improve the regulation of the health care professions and other relevant information and recommendations determined necessary by the council .

Since its inception, the HPC has accomplished most of its original legislative mandate. It has been cited as an innovation by the Pew Health Professions Commission in the *Reforming Health Care Workforce Regulation* and was the subject of an article in the *Professional Licensing Report.* The

HPC's objectives for 1998 as outlined in their annual report include collaboration in website development, consolidation of surplus property, and centralization of responsibilities for posting and advertising job vacancies.[29]

Scope of Practice

Scope of practice refers to the authority vested by a state in health professionals who practice in that state. Scopes of practice draw boundaries among the professions delineating what duties can be performed, what prescription authority each one has and under what kinds of supervision duties can be performed. Scopes of practice, licensure, prescriptive authority, and reimbursement often create exclusive domains of control over the delivery of specific services.

In the Pew Commission's report on responses to the 1995 workforce regulation task force, the recommendation related to scope of practice received one of the highest scores for "level of concern" and was the one most challenged in written responses to the report. The goal of the Pew Commission's recommendation is to improve the public's access to a competent and effective workforce by removing barriers to the full use of competent health professionals.[30]

The purpose behind regulation is to protect the health and welfare of a citizenry. It is interesting to note however, that any proposal to change a profession's scope of practice requires some negotiation of that profession's self interest with those of at least one other professional group.[31] The Pew Commission Taskforce on Health Care Workforce Regulation describes a regulatory system that "treats practice acts as rewards for the professions rather than as rational mechanisms for cost-effective, high-quality and accessible service delivery by competent providers."[32]

The turmoil in the health care environment has generated a great deal of concern about regulation and scopes of practice at all levels: concern for consumer protection, concern for professional autonomy and livelihoods, concern for quality of care, and concern for cost containment. In an editorial in *Nursing Management* magazine, Leah L. Curtin states that:

> Any attempts to "reform" the regulatory system in today's almost hysterically bottom-line-driven market must be carefully considered, publicly debated and cautiously undertaken. After all is said and done, the issue is that we are experimenting with the

> lives and limbs of individual citizens -- and there isn't even an Institutional Review Board to check up on our ethics... which is precisely why we need strong legislation and regulation as a necessary check and balance against the coercive pull of the "bottom-line."[33]

This high level of concern is manifested by health professions regulations becoming an integral part of state health care reform.[34] There has been a dramatic increase in the number of state workforce laws proposed and passed over the past few years. In 1997 there were 744 licensure and scope of practice laws passed in the United States.[33] This is in sharp contrast to the 149 laws passed in 1995.[35]

Changes in scopes of practice can provide ways to decrease the costs of medical care and increase the delivery of services to at-risk or rural and underserved populations, providing greater access to care. For example, the 75th Legislature passed Senate Bill 786, which expanded the "practice of pharmacy" to include the administration of immunizations and vaccinations to individuals 14 years and older. Each year 50,000 to 70,000 adult Americans die from vaccine-preventable diseases. Especially at risk are those adults 65 and over, the chronically ill, and those with weak immune systems. Vaccinating these populations for flu can prevent 50 to 60 percent of hospitalizations and 80 percent of the deaths from complications from the flu. Pneumococcal infection kills about 40,000 Americans a year. It is estimated that fewer than three in 10 of those at risk receive the pneumococcal vaccine.

Currently the Texas Department of Health, the Texas State Board of Pharmacy and the Centers for Disease Control and Prevention are working to develop the education and training required to ensure that pharmacists have the necessary skill, education and certification to provide this service.

What is most important to consider in this frenzy of legislative activity is that states establish a fair and equitable process of determining changes in scopes of practice based on evaluation criteria that ensure patient safety and quality of care, demonstration of professional competency, potential cost benefits of the change, and increase in ability to expand access to care to rural underserved populations.

Notes

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